Parent Form - Seizure History

Student's Name: _____ Birth Date: _____ School Year: _____ - _____

Parent/Guardian:_____ Home:_____ Cell:_____ Other:_____

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Emergency Contacts (To be called if unable to reach parent) **Please update your school office when contact information changes*

Name: _____ Relationship: _____ (PH): _____ (PH):_____

Name: _____ Relationship: _____ (PH): _____ (PH):_____

1. When was the student diagnosed with seizures or epilepsy? _____
2. What type of seizures does the student have? ☐ Simple Partial ☐ Absence (Petit Mal)
   ☐ Complex (Psychomotor/Temporal lobe) ☐ Infantile Spasm ☐ Atonic Seizures (Drop Attacks)
   ☐ Generalized Tonic-Clonic (Grand Mal) ☐ Myoclonic ☐ Other _____
3. Describe the seizures? _____
4. What medications does the student take at home? _____
   _____
5. Will your child require medication at school? ❒ YES ❒ NO (If yes, complete Medical Form – Seizure/Epilepsy)
   - List medication: _____
6. Does the student have Vagal Nerve Stimulator (VNS)? ❒ YES ❒ NO
7. Will the student wear a helmet at school or during transportation? ❒ YES ❒ NO
8. When was the student's last seizure? _____
9. What might trigger the student's seizures? _____
10. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
    - If yes, please explain:_____
11. Has there been any recent change in the student's seizure patterns? ❒ YES ❒ NO
    - If yes, please explain: _____
12. How long do his/her seizures last? _____
13. Has student ever had more than one seizure in a day? _____ If so, how many? _____
14. Has the student ever had clustering (one or more seizures immediately following the first seizure)? _____
15. Has the student ever had difficulty breathing during the seizure? _____
16. Has the color of the student's lips or nail beds ever changed during a seizure? _____
17. How long should the student rest after a seizure? _____
18. Will you be providing a change of clothes to keep at school? _____
19. Do you want to pick the student up after a seizure? _____
20. Any other concerns that may impact your child's education or health? _____
    _____

Parent/Guardian Signature_____ Date_____

Reviewed by school nurse: _____ Date _____